State of Rhode Island
WAGE TRANSCRIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

This form will not be accepted for filing unless all information is completed.

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

3. INSURER COMPLETE:

This wage transcript is submitted to support a:

☐ **Discontinuation of benefits.** The employee has returned to work at a wage equal or greater than he or she earned at the time of the injury.

☐ **Reduction of benefits.** The employee has returned to work at a wage less than he or she earned at the time of the injury.

Date benefits were discontinued or reduced: _____

Pre-injury average weekly wage, **not** including overtime: _____

4. EMPLOYER COMPLETE:

Post-Injury Earning Information -- WEEKS MUST BE CONSECUTIVE

	Period Start Date	Period End Date	Number of Hours Worked	Payment Rate	Amount of Earnings
Week 1					
Week 2					

Employer Name: _____

Address: _____

City, State Zip: _____ Phone: _____

Employer Signature: Date: